PERIODIC HEALTH ASSESSMENT (PHA) NAVMED FORM

UNITED STATES MARINE CORPS

DATE:_____

SCREENING:
Height: (inches)

Weight: (pounds)

Temperature:

deferred

Respirations:

Deferred

Blood Pressure:

Pulse:

MEDICAL EQUIPMENT:

- **Prescription Lenses (two pairs)** Y / N / NA
- **Ballistic Inserts Eyewear** Y/ N/ NA
- **Gas Mask Inserts** Y / N / NA
- **Medical Alert Tags** Y / N / NA

S: SUBJECTIVE

_____ year old ❑ male ❑ female reports for an annual Preventive Health Assessment (PHA) which includes record review/verification, assessment and counseling of avoidable health risk factors, clinical preventive services (CPS), and individual medical readiness (IMR) assessment IAW MANMED.

Allergies (Medication and other): See Block 1 on DD2766
Chronic Illnesses: See Block 2 on DD2766
Medications (Rx./OTC/herbals/supplements/performance enhancers): See Block 3 on DD2766
Hospitalizations / Surgeries since last PHA: See Block 4 on DD 2766
Family History: See Block 6 on DD2766
Occupational History: See Block 8 on DD2766
Deployment Health: See Block 11 on DD2766
Deployed since the previous PHA? ❑Yes ❑No
Post-Deployment Health Assessment (DD2796) in record? ❑Yes ❑No ❑NA
If 90 days or greater after return from deployment, is PDHRA in record? □ Yes □ No
Any unresolved deployment-related issues or health concerns? ❑Yes ❑No ❑NA
Comments:_____

O: OBJECTIVE

Vital Signs noted. Remarkable for: ❑None ❑Other:

Physical examination is otherwise deferred.

Medical Record ❑Reviewed ❑Not available ❑Remarkable for: _____
Immunization record ❑Reviewed ❑Not available ❑Remarkable for: _____
Lab/Path results ❑Reviewed ❑Not available ❑Remarkable for: _____

A: ASSESSMENT Annual Preventive Health Assessment visit
Health Risk Level (Fleet HRA): _____%
Health Risks remarkable for the following: _____
Other significant issues remarkable for: _____

Health Assessment Report Tool: Completed and reviewed? ❑Yes ❑Not Available
Current health concerns? _____

On Limited Duty (LIMDU) ❑ Yes ❑ No ❑ N/A ❑ Comments:_____

Medical Board ❑ Yes ❑ No ❑ N/A ❑ Comments:_____

❑ **TNPQ,** ❑ **TNDQ,** ❑ **NPQ or** ❑ **LOD** ❑ Comments:_____

PATIENT'S IDENTIFICATION ***(Use this space for Mechanical Imprint Telephone number and e-mail address for follow-up:***

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
SSN/IDENTIFICATION NO.	STATUS	RANK/GRADE
RECORDS MAINTAINED AT:		DATE OF BIRTH

P: PLAN / P: PREVENTION

1. Updated DD 2766 and MRRS Database ❑ Yes ❑ No ❑ N/A ❑ Other:_____

2. Health counseling performed, documented on the DD2766, Section 5.

3. Labs ordered for the following: ❑None ❑Blood Type ❑G6PD ❑HIV ❑Blood Type ❑DNA ❑Sickle Cell Screen ❑Fasting Lipid ❑Other: _____

4. Referred to immunizations for the following: ❑None ❑PPD ❑MMR ❑Td ❑IPV ❑HepA #1 #2 ❑Influenza ❑Yellow Fever ❑Hep B #1 #2 #3 ❑Typhoid ❑Other: _____

5. Clinical Preventive Services recommended: ❑None ❑Pap ❑Chlamydia ❑Mammogram ❑Clinical Breast Exam ❑Colorectal ❑Prostate ❑Lipids ❑Other: _____

6. Dental services completed: ❑ Bitewings ❑ Panograph ❑ Annual T-2 Dental Exam ❑ Dental Class 3 ❑ Dental Class 4 ❑ Other: _____

7. Referred to PCM or Civilian Healthcare Provider for: ❑None ❑Cholesterol ❑Hypertension ❑Pap ❑Chlamydia ❑Clinical Breast Exam ❑Deployment-Related Condition ❑Chronic/Current Illness ❑ Other: _____

8. Preventive Counseling provided for: ❑None ❑ Tobacco Use ❑ Physical Activity ❑ Dental Care ❑ Alcohol Use ❑Nutrition ❑Mental Health ❑ Sexuality ❑Safety ❑Other: _____

9. Other indicated referrals: ❑None ❑Audiology ❑Optometry ❑Behavioral Health ❑ BMI ❑ Deployment-Related Condition ❑Occl Health ❑Chaplain ❑ Medical Warning Tags ❑ Weight Management ❑ Tobacco ❑Cessation ❑Other: _____

10. Member cleared for PFT participation? ❑Yes ❑No (Refer to PCM for PFT Screening)
Reason for waiver:_____

11. Additional Comments: _____
_____
_____
_____
_____
_____
_____

12. Member readiness reviewed and updated in approved electronic data system.

13. Member informed that completion of recommended tests / immunizations / screenings are to be performed within the next 30 days, and are personally responsible for maintaining individual medical readiness (IMR).
Member voiced understanding of instructions. ❑ Yes ❑ No ❑ N/A

Member Signature:_____Date:_____

MDR Signature:_____Date:_____

Health Promotion Counselor Signature:_____ Date:_____

Provider Signature and Title: _____Date: Completed:_____